Filing at a Glance

Company:	American Family Life Assurance Company of Columbus
Product Name:	Medicare Supplement Filing
State:	Arkansas
TOI:	MS08I Individual Medicare Supplement - Standard Plans 2010
Sub-TOI:	MS08I.012 Multi-Plan 2010
Filing Type:	Form/Rate
Date Submitted:	07/27/2012
SERFF Tr Num:	FRCS-128603622
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	5786
Implementation Date Requested:	On Approval
Author(s):	Michael Cochran, Kevin Wiggs
Reviewer(s):	Stephanie Fowler (primary)
Disposition Date:	08/21/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

General Information

Project Name: AFLAC/61

Project Number: 61

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Exselsa Cartwright

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Pending in domicile state of Nebraska.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 08/21/2012

State Status Changed: 08/21/2012

Created By: Michael Cochran

Corresponding Filing Tracking Number:

Filing Description:

We have been retained by American Family Life Assurance Company of Columbus to file the enclosed forms for approval in your state.

Our fee of $650 has been sent via EFT, on this same date.

The Company offers their assurance that the information required by Section 23-79-138 will be provided.

The Company offers their assurance that the Guaranty Association notice required by Regulation 49 will be provided.

The attached Medicare Supplement Insurance Policies were developed to provide the Medicare supplement benefits required of standardized Plans A, C, D, F, G and N, respectively. All of these policies contain identical wording, except for the different standardized benefits applicable to each particular plan.

The captioned forms will be made available to persons eligible for Medicare by reason of age.

The rates for the policies are enclosed.

Advertising for the policies will be filed separately under separate cover.

The application will be used to apply for these new Medicare supplement policies.

The Outline of Coverage has been bracketed to reflect variability to allow for flexibility as to what plans are offered by the Company. Please be assured that only those plans that have been approved by your state will be shown. The rate page will reflect the rates approved for your state. The disclosure and benefit chart pages contain all necessary information required by the NAIC model.

We ask that the Outline of Coverage form also be considered as variable to the extent that rates, telephone numbers, addresses, dates, federal co-payments, deductibles and other variable material can change over time when appropriate and when amended by regulation.

Variability is also requested for the bracketed telephone numbers, administrative office address and officer signatures shown within the policy.

State:	*Arkansas*	***Filing Company:***	*American Family Life Assurance Company of Columbus*
TOI/Sub-TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*		
Product Name:	*Medicare Supplement Filing*		
Project Name/Number:	*AFLAC/61/61*		

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

Company and Contact

Filing Contact Information

Michael Cochran, Compliance Specialist
1020 Central
Suite 201
Kansas City, MO 64105

michael.cochran@firstconsulting.com
800-927-2730 [Phone] 2756 [Ext]
816-391-2755 [FAX]

Filing Company Information

(This filing was made by a third party - FC01)

American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, GA 31999
(706) 660-7077 ext. [Phone]

CoCode: 60380
Group Code: 370
Group Name: AFLAC Incorporated Group
FEIN Number: 58-0663085

State of Domicile: Nebraska
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$650.00
Retaliatory?	No
Fee Explanation:	$50 per form x 12 forms = $600, $50 per rate x 1 = $50, Total = $650
Per Company:	No

Company	Amount	Date Processed	Transaction #
American Family Life Assurance Company of Columbus	$650.00	07/27/2012	61254398

SERFF Tracking #:	*FRCS-128603622*	***State Tracking #:***		***Company Tracking #:***	*5786*

State:	*Arkansas*	***Filing Company:***	*American Family Life Assurance Company of Columbus*
TOI/Sub-TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*		
Product Name:	*Medicare Supplement Filing*		
Project Name/Number:	*AFLAC/61/61*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/21/2012	08/21/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	08/15/2012	08/15/2012
Pending Industry Response	Stephanie Fowler	08/02/2012	08/02/2012

Response Letters

Responded By	Created On	Date Submitted
Michael Cochran	08/20/2012	08/20/2012
Michael Cochran	08/08/2012	08/13/2012

SERFF Tracking #:	*FRCS-128603622*	***State Tracking #:***		***Company Tracking #:***	*5786*

State:	*Arkansas*	***Filing Company:***	*American Family Life Assurance Company of Columbus*
TOI/Sub-TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*		
Product Name:	*Medicare Supplement Filing*		
Project Name/Number:	*AFLAC/61/61*		

Disposition

Disposition Date: 08/21/2012
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
American Family Life Assurance Company of Columbus	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #: FRCS-128603622 **State Tracking #:** **Company Tracking #:** 5786

State: Arkansas **Filing Company:** American Family Life Assurance Company of Columbus
TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010
Product Name: Medicare Supplement Filing
Project Name/Number: AFLAC/61/61

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Disapproved	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Medicare Supplement Insurance Policy – Plan A	Approved-Closed	Yes
Form	Medicare Supplement Insurance Policy – Plan C	Approved-Closed	Yes
Form	Medicare Supplement Insurance Policy – Plan D	Approved-Closed	Yes
Form	Medicare Supplement Insurance Policy – Plan F	Approved-Closed	Yes
Form	Medicare Supplement Insurance Policy – Plan G	Approved-Closed	Yes
Form	Medicare Supplement Insurance Policy – Plan N	Approved-Closed	Yes
Form (revised)	Application for Medicare Supplement Insurance	Approved-Closed	Yes
Form	Application for Medicare Supplement Insurance	Disapproved	No
Form	Application for Medicare Supplement Insurance	Disapproved	No
Form	Outline of Coverage	Approved-Closed	Yes
Form	Amendment to Application	Approved-Closed	Yes
Form	Application for Reinstatement	Approved-Closed	Yes
Form	Notice to Applicant Regarding Replacement	Approved-Closed	Yes
Form	Request for Change	Approved-Closed	Yes
Rate (revised)	Rates	Approved-Closed	Yes
Rate	Rates	Disapproved	No

SERFF Tracking #: FRCS-128603622 **State Tracking #:** **Company Tracking #:** 5786

State: Arkansas **Filing Company:** American Family Life Assurance Company of Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: Medicare Supplement Filing

Project Name/Number: AFLAC/61/61

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/15/2012
Submitted Date	08/15/2012
Respond By Date	09/17/2012

Dear Michael Cochran,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Health - Actuarial Justification (Supporting Document)

- Rates, [A19MSARAR, A19MSCRAR, A19MSDRAR, A19MSFRAR, A19MSGRAR, A19MSNRAR] (Rate)

Comments: AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium."

Please revise this filing to comply.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

SERFF Tracking #:	FRCS-128603622	**State Tracking #:**		**Company Tracking #:**	5786

State:	Arkansas	**Filing Company:**	American Family Life Assurance Company of Columbus
TOI/Sub-TOI:	MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010		
Product Name:	Medicare Supplement Filing		
Project Name/Number:	AFLAC/61/61		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/20/2012
Submitted Date	08/20/2012

Dear Stephanie Fowler,

Introduction:

In response to your objection letter dated 8-15-12, on behalf of the Company, we offer the following for your consideration.

Response 1

Comments:

The company has revised the rates to delete reference to the policy fee. Please see the revised Rates and Actuarial memo.

This change necessitated a revision to the application, on page 1, to delete the reference to Policy Fee. The reference was deleted from page 1, and other items moved accordingly. The form number remains the same.

Related Objection 1

Applies To:

- *Rates, [A19MSARAR, A19MSCRAR, A19MSDRAR, A19MSFRAR, A19MSGRAR, A19MSNRAR] (Rate)*
- *Health - Actuarial Justification (Supporting Document)*

Comments: AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium."

Please revise this filing to comply.

Changed Items:

Supporting Document Schedule Item Changes
Satisfied -Name: Health - Actuarial Justification
Comment:

SERFF Tracking #: FRCS-128603622 **State Tracking #:** **Company Tracking #:** 5786

State: Arkansas **Filing Company:** American Family Life Assurance Company of Columbus
TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010
Product Name: Medicare Supplement Filing
Project Name/Number: AFLAC/61/61

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	A19MS1RAR	AEF	Application for Medicare Supplement Insurance	Initial	45.000	A19MS1R-AR.pdf	Date Submitted: 08/20/2012 By: Michael Cochran
Previous Version							
1	*A19MS1RAR*	*AEF*	*Application for Medicare Supplement Insurance*	*Initial*	*45.000*	*A19MS1R-AR.pdf*	*Date Submitted: 08/20/2012 By: Michael Cochran*
1	*A19MS1R*	*AEF*	*Application for Medicare Supplement Insurance*	*Initial*	*45.000*	*A19MS1R.pdf*	*Date Submitted: 08/20/2012 By: Michael Cochran*

SERFF Tracking #:	*FRCS-128603622*	***State Tracking #:***		***Company Tracking #:***	*5786*

State:	*Arkansas*	***Filing Company:***	*American Family Life Assurance Company of Columbus*
TOI/Sub-TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*		
Product Name:	*Medicare Supplement Filing*		
Project Name/Number:	*AFLAC/61/61*		

Rate/Rule Schedule Item Changes

Document Name	Affected Form Numbers	Rate Action*	Rate Action Information	Attachments
Rates	A19MSARAR, A19MSCRAR, A19MSDRAR, A19MSFRAR, A19MSGRAR, A19MSNRAR	New	*Previous State Filing Number* *0*	
Previous Version				
Rates	*A19MSARAR, A19MSCRAR, A19MSDRAR, A19MSFRAR, A19MSGRAR, A19MSNRAR*	*New*	*Previous State Filing Number* *0*	

Conclusion:

We trust this information will allow you to finalize review of this filing. If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you for your assistance.

Sincerely,

Michael Cochran

SERFF Tracking #: FRCS-128603622 **State Tracking #:** **Company Tracking #:** 5786

State: Arkansas **Filing Company:** American Family Life Assurance Company of Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: Medicare Supplement Filing

Project Name/Number: AFLAC/61/61

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/02/2012
Submitted Date	08/02/2012
Respond By Date	09/03/2012

Dear Michael Cochran,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Medicare Supplement Insurance, A19MS1R (Form)

Comments: R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Medical Question section since it is not required to be answered during Open Enrollment.

Objection 2

- Amendment to Application, AC-ATA (Form)

- Application for Reinstatement, ACREST (Form)

Comments: These two forms appear to be the same document. Please attach the correct forms.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

SERFF Tracking #:	FRCS-128603622	**State Tracking #:**		**Company Tracking #:**	5786

State:	Arkansas	**Filing Company:**	American Family Life Assurance Company of Columbus
TOI/Sub-TOI:	MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010		
Product Name:	Medicare Supplement Filing		
Project Name/Number:	AFLAC/61/61		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/08/2012
Submitted Date	08/13/2012

Dear Stephanie Fowler,

Introduction:

In response to your objection letter dated 8/2/2012, on behalf of American Family Life Assurance Company of Columbus, we offer the following for your consideration.

Response 1

Comments:

The Tobacco Use question has been moved to the Health Questions section. Please note that the attached Application has been renumbered as A19MS1RAR.

Related Objection 1

Applies To:

- Application for Medicare Supplement Insurance, A19MS1R (Form)

Comments: R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Medical Question section since it is not required to be answered during Open Enrollment.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	FRCS-128603622	**State Tracking #:**		**Company Tracking #:**	5786

State:	Arkansas	**Filing Company:**	American Family Life Assurance Company of Columbus
TOI/Sub-TOI:	MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010		
Product Name:	Medicare Supplement Filing		
Project Name/Number:	AFLAC/61/61		

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	A19MS1RAR	AEF	Application for Medicare Supplement Insurance	Initial	45.000	A19MS1R-AR.pdf	Date Submitted: 08/13/2012 By: Michael Cochran
Previous Version							
1	A19MS1R	AEF	Application for Medicare Supplement Insurance	Initial	45.000	A19MS1R.pdf	Date Submitted: 08/13/2012 By: Michael Cochran

No Rate/Rule Schedule items changed.

Response 2

Comments:

Per your phone conversation with Scott Sheffer on 8/7/2012, you confirmed that the Amendment to Application, form AC-ATA and the Reinstatement Application, form ACREST, were appropriately attached in the SERFF filing and are in order.

Related Objection 2

Applies To:

- Amendment to Application, AC-ATA (Form)
- Application for Reinstatement, ACREST (Form)

SERFF Tracking #:	FRCS-128603622	**State Tracking #:**		**Company Tracking #:**	5786

State:	Arkansas	**Filing Company:**	American Family Life Assurance Company of Columbus
TOI/Sub-TOI:	MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010		
Product Name:	Medicare Supplement Filing		
Project Name/Number:	AFLAC/61/61		

Comments: These two forms appear to be the same document. Please attach the correct forms.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

We trust this information will allow you to finalize review of this filing. If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you for your assistance.

Sincerely,

Michael Cochran

SERFF Tracking #: FRCS-128603622 **State Tracking #:** **Company Tracking #:** 5786

State: Arkansas **Filing Company:** American Family Life Assurance Company of Columbus
TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010
Product Name: Medicare Supplement Filing
Project Name/Number: AFLAC/61/61

Form Schedule

Lead Form Number: A19MSARAR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 08/21/2012	A19MSARAR	POL	Medicare Supplement Insurance Policy – Plan A	Initial:	46.900	A19MSAR-AR.pdf
2	Approved-Closed 08/21/2012	A19MSCRAR	POL	Medicare Supplement Insurance Policy – Plan C	Initial:	49.200	A19MSCR-AR.pdf
3	Approved-Closed 08/21/2012	A19MSDRAR	POL	Medicare Supplement Insurance Policy – Plan D	Initial:	49.700	A19MSDR-AR.pdf
4	Approved-Closed 08/21/2012	A19MSFRAR	POL	Medicare Supplement Insurance Policy – Plan F	Initial:	50.700	A19MSFR-AR.pdf
5	Approved-Closed 08/21/2012	A19MSGRAR	POL	Medicare Supplement Insurance Policy – Plan G	Initial:	51.800	A19MSGR-AR.pdf
6	Approved-Closed 08/21/2012	A19MSNRAR	POL	Medicare Supplement Insurance Policy – Plan N	Initial:	52.000	A19MSNR-AR.pdf
7	Approved-Closed 08/21/2012	A19MS1RAR	AEF	Application for Medicare Supplement Insurance	Initial:	45.000	A19MS1R-AR.pdf
8	Approved-Closed 08/21/2012	ACOCRAR	OUT	Outline of Coverage	Initial:	45.000	ACOCR bracketed-AR.pdf
9	Approved-Closed 08/21/2012	AC-ATA	AEF	Amendment to Application	Initial:	45.000	AC-ATA.pdf
10	Approved-Closed 08/21/2012	ACREST	AEF	Application for Reinstatement	Initial:	45.000	ACREST.pdf
11	Approved-Closed 08/21/2012	A19MS15	NOC	Notice to Applicant Regarding Replacement	Initial:	45.000	A19MS15.pdf

SERFF Tracking #:	*FRCS-128603622*	***State Tracking #:***		***Company Tracking #:***	*5786*

State:	*Arkansas*	***Filing Company:***	*American Family Life Assurance Company of Columbus*
TOI/Sub-TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*		
Product Name:	*Medicare Supplement Filing*		
Project Name/Number:	*AFLAC/61/61*		

Lead Form Number: A19MSARAR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
12	Approved-Closed 08/21/2012	A19MS4	OTH	Request for Change	Initial:	45.000	A19MS4.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
WORLDWIDE HEADQUARTERS
[1932 Wynnton Road]
[Columbus, GA 31999]

DIRECT ALL INQUIRIES TO:
AFLAC MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
[P.O. Box 1553]
[Pensacola, Florida 32591]
[1.888.207.2078]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN A

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.
READ YOUR POLICY CAREFULLY.

This policy provides benefits to supplement the Hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this policy. The Named Insured shown in the Policy Schedule will be referred to as “you,” “your,” or “yours.” **American Family Life Assurance Company of Columbus,** a stock company, will be referred to as "we," "our," "us," or “Aflac.”

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare supplement insurance policy is based on your answers to the questions on your application. A copy of the application is attached. Omissions or misstatements on the application could cause your claim to be denied or your policy to be rescinded. If for any reason your answers are incorrect, please contact us immediately at our Medicare Supplement Administrative Office.

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this policy. The term of this policy begins at 12:01 a.m. Standard time, at the place where you reside, on the Policy Effective Date shown in the Policy Schedule. It ends at midnight, Standard time, at the place where you reside, on the day before your premium is due. The date your premium is due is determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule.

30-DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read your policy carefully. If for any reason you are not satisfied, you may return your policy to us within 30 days after receiving it. If returned, the policy will be void from its beginning, and any premium paid will be refunded, less any claims paid.

GUARANTEED-RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This policy is guaranteed-renewable as long as you live, provided you continue to pay premiums when due. At no time, while you continue your policy in force, may we place any restrictive riders on your coverage. Your *policy anniversary date* is the same month and day as the Policy Effective Date for each succeeding year this policy remains in force. The premium may change on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as underwriting class, state of issue, and your most recent ZIP Code of residence. We will give you at least 30 days’ advance written notice if a new table of rates is applicable to the policy.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION.
THIS IS A NONPARTICIPATING POLICY.

TABLE OF CONTENTS

POLICY SCHEDULE

INSURED:	**POLICY EFFECTIVE DATE:**
POLICY NUMBER:	**ISSUE AGE:**
SEX:	**STATE OF ISSUE:**
MODE AT ISSUE:	**MODAL PREMIUM:**
PREMIUM TERM:	**UNDERWRITING CLASS:**

****

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN A

DEFINITIONS

Benefit Period means the period as determined by Medicare, which begins on the date you are first confined in a Hospital. It ends following a period of 60 consecutive days during which you have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare-Eligible Expenses you have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a Hospital that is approved, or eligible to be approved, to receive payments from Medicare and that is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or **Hospitalization** means being confined in a Hospital on an inpatient basis.

Immediate Family means your spouse; parents; grandparents; children; or siblings and spouses, as applicable, of any of these.

Injury means a bodily Injury that is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of 60 extra days in the Hospital provided to you by Medicare. These reserve days must be used if you are Hospitalized for more than 90 days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days you have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with generally accepted standards or medical practice; and (4) not solely for the convenience of you or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare-Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include you or any member of your Immediate Family.

Policy Effective Date means the effective date of this policy and is shown in the Policy Schedule. The Policy Effective Date is not the date you signed the application for coverage.

Sickness means illness or disease that first manifests itself after the Policy Effective Date and while this policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and operated within the scope and intent of its license. It does not include a facility or any of its sections that is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare-Eligible Expenses not paid by Medicare. Benefits are paid only to the extent specified in this provision.

The benefits paid under this policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare-Eligible Expenses for Hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

Coverage of Part A Medicare-Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Part A Medicare-Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider will accept our payment as payment in full and may not bill you for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare-Eligible Expenses under Part B, regardless of Hospital confinement, subject to the Medicare Part B Deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare-Eligible Expenses for hospice care and respite care expenses.

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this policy will automatically change to reflect any changes that will become effective under Medicare deductibles, copayments, or Coinsurance Amounts. Only those provisions of the policy that are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on Page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this policy are suspended at your request for a period not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify us within 90 days after the day you become entitled to such assistance.

If such a suspension occurs and you lose entitlement of such medical assistance, your policy is automatically reinstituted effective as of the date of termination of such entitlement if you provide notice of loss of such entitlement within 90 days after the date of such loss and pay the premiums attributable to the period. Your reinstituted policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this policy will be suspended for any period that may be provided by federal regulation at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan, as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and you lose coverage under the group health plan, your policy will be automatically reinstituted, effective as of the date of loss of such coverage, if you provide notice of loss of coverage within 90 days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of your coverage provides for:

- No waiting period with respect to treatment of pre-existing conditions.
- Coverage equivalent to the coverage in effect before the date of suspension.
- Your classification of premium to be as favorable to you as the premium classification terms that would have applied to you had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this policy, an extension of benefits will be granted for any continuous loss that commenced during a period where the policy was in force and the premium was paid. This extension of benefits beyond the period during which the policy was in force may be conditioned upon your continuous total disability, limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- Expenses incurred while this policy is not in force, except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- That portion of any expense incurred that is paid for by Medicare;
- Services for non-Medicare-Eligible Expenses, unless specifically covered in the policy, including but not limited to routine exams, take-home drugs, and eye refractions;
- Services for which a charge is not normally made in the absence of insurance;
- Loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this policy will be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for the policy will be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the two-year period.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium due after the initial premium. The policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due, and claims incurred on or after that date will not be considered for payment. A grace period does not apply if you cancel your policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by us for payment, a subsequent acceptance of any premium by us or by any of our authorized agents, without requiring an application for reinstatement, will reinstate the policy, provided, however, that if we or any of our authorized agents require an application for reinstatement and issue a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt, unless we have previously notified you in writing of our disapproval of such application. The reinstated policy will cover only loss resulting from Injury or Sickness beginning on or after the date of reinstatement. In all other respects the company and the insured will have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within 20 days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Aflac, Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLAIM FORMS: When we receive the notice, we will send you forms for filing proof of loss. If we do not send the forms within 15 working days after receiving written notice, our requirements will be met if we receive written proof of the event, and the type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within 90 days after the date the loss began or occurred. If it is not reasonably possible to give timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, we will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to you or to any health care provider to whom you have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at your death will be paid to your estate or to any health care providers to whom you have assigned benefits. If we fail to pay the benefits payable upon receipt of due written proof of loss, we will have 15 working days thereafter to mail you a letter or notice that states the reasons we have for failing to pay the claim, either in whole or in part, and that also gives you a written itemization of any documents or other information needed to process the claim or any portions thereof that are not being paid. When all of the listed documents or other information needed to process the claim have been received, we will then have 15 working days to process and either pay the claim or deny it, in whole or in part, giving you the reasons we may have for denying such claim or any portion thereof.

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare-Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us, or your health care provider may submit it to us on your behalf.

PHYSICAL EXAMINATIONS: At our expense, we may have you examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity will be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the policy that, on its Policy Effective Date, is in conflict with the laws of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim will bind us, unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Aflac Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLERICAL ERROR: Clerical error on our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

MISSTATEMENT OF AGE: If your age has been misstated, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age.

PRO RATA REFUND: If we receive written proof of death that terminates coverage, we will refund that part of any premium you have paid that covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this policy at any time by written notice delivered or mailed to us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we will make a pro rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation, except as provided for under the Extension of Benefits provision.

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the Policy Effective Date shown in the Policy Schedule.

[

Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
WORLDWIDE HEADQUARTERS
[1932 Wynnton Road]
[Columbus, GA 31999]

DIRECT ALL INQUIRIES TO:
AFLAC MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
[P.O. Box 1553]
[Pensacola, Florida 32591]
[1.888.207.2078]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN C

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.
READ YOUR POLICY CAREFULLY.

This policy provides benefits to supplement the Hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this policy. The Named Insured shown in the Policy Schedule will be referred to as “you,” “your,” or “yours.” **American Family Life Assurance Company of Columbus,** a stock company, will be referred to as "we," "our," "us," or “Aflac.”

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare supplement insurance policy is based on your answers to the questions on your application. A copy of the application is attached. Omissions or misstatements on the application could cause your claim to be denied or your policy to be rescinded. If for any reason your answers are incorrect, please contact us immediately at our Medicare Supplement Administrative Office.

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this policy. The term of this policy begins at 12:01 a.m. Standard time, at the place where you reside, on the Policy Effective Date shown in the Policy Schedule. It ends at midnight, Standard time, at the place where you reside, on the day before your premium is due. The date your premium is due is determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule.

30-DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read your policy carefully. If for any reason you are not satisfied, you may return your policy to us within 30 days after receiving it. If returned, the policy will be void from its beginning, and any premium paid will be refunded, less any claims paid.

GUARANTEED-RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This policy is guaranteed-renewable as long as you live, provided you continue to pay premiums when due. At no time, while you continue your policy in force, may we place any restrictive riders on your coverage. Your *policy anniversary date* is the same month and day as the Policy Effective Date for each succeeding year this policy remains in force. The premium may change on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as underwriting class, state of issue, and your most recent ZIP Code of residence. We will give you at least 30 days’ advance written notice if a new table of rates is applicable to the policy.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION.
THIS IS A NONPARTICIPATING POLICY.

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POLICY SCHEDULE

INSURED:	**POLICY EFFECTIVE DATE:**
POLICY NUMBER:	**ISSUE AGE:**
SEX:	**STATE OF ISSUE:**
MODE AT ISSUE:	**MODAL PREMIUM:**
PREMIUM TERM:	**UNDERWRITING CLASS:**

****

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN C

DEFINITIONS

Benefit Period means the period as determined by Medicare, which begins on the date you are first confined in a Hospital. It ends following a period of 60 consecutive days during which you have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare-Eligible Expenses you have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a Hospital that is approved, or eligible to be approved, to receive payments from Medicare and that is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or **Hospitalization** means being confined in a Hospital on an inpatient basis.

Immediate Family means your spouse; parents; grandparents; children; or siblings and spouses, as applicable, of any of these.

Injury means a bodily Injury that is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of 60 extra days in the Hospital provided to you by Medicare. These reserve days must be used if you are Hospitalized for more than 90 days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days you have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with generally accepted standards or medical practice; and (4) not solely for the convenience of you or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare-Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Medicare Part B Deductible means the fixed amount you must pay each Calendar Year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount. A Calendar Year begins on January 1 and ends on December 31.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include you or any member of your Immediate Family.

Policy Effective Date means the effective date of this policy and is shown in the Policy Schedule. The Policy Effective Date is not the date you signed the application for coverage.

DEFINITIONS – CONTINUED

Sickness means illness or disease that first manifests itself after the Policy Effective Date and while this policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and operated within the scope and intent of its license. It does not include a facility or any of its sections that is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare-Eligible Expenses not paid by Medicare. Benefits are paid only to the extent specified in this provision.

The benefits paid under this policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare-Eligible Expenses for Hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

Coverage of Part A Medicare-Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Part A Medicare-Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider will accept our payment as payment in full and may not bill you for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare-Eligible Expenses under Part B, regardless of Hospital confinement, subject to the Medicare Part B Deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare-Eligible Expenses for hospice care and respite care expenses.

Additional Benefits for Plan C

Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

Medicare Part B Deductible: Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

Additional Benefits for Plan C – Continued

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year deductible of $250 and a lifetime maximum benefit of $50,000.

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this policy will automatically change to reflect any changes that will become effective under Medicare deductibles, copayments, or Coinsurance Amounts. Only those provisions of the policy that are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on Page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this policy are suspended at your request for a period not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify us within 90 days after the day you become entitled to such assistance.

If such a suspension occurs and you lose entitlement of such medical assistance, your policy is automatically reinstituted effective as of the date of termination of such entitlement if you provide notice of loss of such entitlement within 90 days after the date of such loss and pay the premiums attributable to the period. Your reinstituted policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this policy will be suspended for any period that may be provided by federal regulation at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan, as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and you lose coverage under the group health plan, your policy will be automatically reinstituted, effective as of the date of loss of such coverage, if you provide notice of loss of coverage within 90 days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of your coverage provides for:

- No waiting period with respect to treatment of pre-existing conditions.
- Coverage equivalent to the coverage in effect before the date of suspension.
- Your classification of premium to be as favorable to you as the premium classification terms that would have applied to you had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this policy, an extension of benefits will be granted for any continuous loss that commenced during a period where the policy was in force and the premium was paid. This extension of benefits beyond the period during which the policy was in force may be conditioned upon your continuous total disability, limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- Expenses incurred while this policy is not in force, except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- That portion of any expense incurred that is paid for by Medicare;
- Services for non-Medicare-Eligible Expenses, unless specifically covered in the policy, including but not limited to routine exams, take-home drugs, and eye refractions;
- Services for which a charge is not normally made in the absence of insurance;
- Loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this policy will be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for the policy will be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the two-year period.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium due after the initial premium. The policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due, and claims incurred on or after that date will not be considered for payment. A grace period does not apply if you cancel your policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by us for payment, a subsequent acceptance of any premium by us or by any of our authorized agents, without requiring an application for reinstatement, will reinstate the policy, provided, however, that if we or any of our authorized agents require an application for reinstatement and issue a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt, unless we have previously notified you in writing of our disapproval of such application. The reinstated policy will cover only loss resulting from Injury or Sickness beginning on or after the date of reinstatement. In all other respects the company and the insured will have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within 20 days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Aflac, Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLAIM FORMS: When we receive the notice, we will send you forms for filing proof of loss. If we do not send the forms within 15 working days after receiving written notice, our requirements will be met if we receive written proof of the event, and the type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within 90 days after the date the loss began or occurred. If it is not reasonably possible to give timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, we will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to you or to any health care provider to whom you have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at your death will be paid to your estate or to any health care providers to whom you have assigned benefits. If we fail to pay the benefits payable upon receipt of due written proof of loss, we will have 15 working days thereafter to mail you a letter or notice that states the reasons we have for failing to pay the claim, either in whole or in part, and that also gives you a written itemization of any documents or other information needed to process the claim or any portions thereof that are not being paid. When all of the listed documents or other information needed to process the claim have been received, we will then have 15 working days to process and either pay the claim or deny it, in whole or in part, giving you the reasons we may have for denying such claim or any portion thereof.

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare-Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us, or your health care provider may submit it to us on your behalf.

PHYSICAL EXAMINATIONS: At our expense, we may have you examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity will be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the policy that, on its Policy Effective Date, is in conflict with the laws of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim will bind us, unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Aflac Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLERICAL ERROR: Clerical error on our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

MISSTATEMENT OF AGE: If your age has been misstated, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age .

PRO RATA REFUND: If we receive written proof of death that terminates coverage, we will refund that part of any premium you have paid that covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this policy at any time by written notice delivered or mailed to us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we will make a pro rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation, except as provided for under the Extension of Benefits provision.

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the Policy Effective Date shown in the Policy Schedule.

[

Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
WORLDWIDE HEADQUARTERS
[1932 Wynnton Road]
[Columbus, GA 31999]

DIRECT ALL INQUIRIES TO:
AFLAC MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
[P.O. Box 1553]
[Pensacola, Florida 32591]
[1.888.207.2078]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN D

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.
READ YOUR POLICY CAREFULLY.

This policy provides benefits to supplement the Hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this policy. The Named Insured shown in the Policy Schedule will be referred to as “you,” “your,” or “yours.” **American Family Life Assurance Company of Columbus,** a stock company, will be referred to as "we," "our," "us," or “Aflac.”

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare supplement insurance policy is based on your answers to the questions on your application. A copy of the application is attached. Omissions or misstatements on the application could cause your claim to be denied or your policy to be rescinded. If for any reason your answers are incorrect, please contact us immediately at our Medicare Supplement Administrative Office.

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this policy. The term of this policy begins at 12:01 a.m. Standard time, at the place where you reside, on the Policy Effective Date shown in the Policy Schedule. It ends at midnight, Standard time, at the place where you reside, on the day before your premium is due. The date your premium is due is determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule.

30-DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read your policy carefully. If for any reason you are not satisfied, you may return your policy to us within 30 days after receiving it. If returned, the policy will be void from its beginning, and any premium paid will be refunded, less any claims paid.

GUARANTEED-RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This policy is guaranteed-renewable as long as you live, provided you continue to pay premiums when due. At no time, while you continue your policy in force, may we place any restrictive riders on your coverage. Your *policy anniversary date* is the same month and day as the Policy Effective Date for each succeeding year this policy remains in force. The premium may change on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as underwriting class, state of issue, and your most recent ZIP Code of residence. We will give you at least 30 days’ advance written notice if a new table of rates is applicable to the policy.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION.
THIS IS A NONPARTICIPATING POLICY.

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POLICY SCHEDULE

INSURED:	**POLICY EFFECTIVE DATE:**
POLICY NUMBER:	**ISSUE AGE:**
SEX:	**STATE OF ISSUE:**
MODE AT ISSUE:	**MODAL PREMIUM:**
PREMIUM TERM:	**UNDERWRITING CLASS:**

****

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN D

DEFINITIONS

Benefit Period means the period as determined by Medicare, which begins on the date you are first confined in a Hospital. It ends following a period of 60 consecutive days during which you have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare-Eligible Expenses you have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a Hospital that is approved, or eligible to be approved, to receive payments from Medicare and that is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or **Hospitalization** means being confined in a Hospital on an inpatient basis.

Immediate Family means your spouse; parents; grandparents; children; or siblings and spouses, as applicable, of any of these.

Injury means a bodily Injury that is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of 60 extra days in the Hospital provided to you by Medicare. These reserve days must be used if you are Hospitalized for more than 90 days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days you have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with generally accepted standards or medical practice; and (4) not solely for the convenience of you or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare-Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include you or any member of your Immediate Family.

Policy Effective Date means the effective date of this policy and is shown in the Policy Schedule. The Policy Effective Date is not the date you signed the application for coverage.

Sickness means illness or disease that first manifests itself after the Policy Effective Date and while this policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and operated within the scope and intent of its license. It does not include a facility or any of its sections that is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare-Eligible Expenses not paid by Medicare. Benefits are paid only to the extent specified in this provision.

The benefits paid under this policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare-Eligible Expenses for Hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

Coverage of Part A Medicare-Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Part A Medicare-Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider will accept our payment as payment in full and may not bill you for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare-Eligible Expenses under Part B, regardless of Hospital confinement, subject to the Medicare Part B Deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare-Eligible Expenses for hospice care and respite care expenses.

Additional Benefits for Plan D

Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year deductible of $250 and a lifetime maximum benefit of $50,000.

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this policy will automatically change to reflect any changes that will become effective under Medicare deductibles, copayments, or Coinsurance Amounts. Only those provisions of the policy that are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on Page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this policy are suspended at your request for a period not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify us within 90 days after the day you become entitled to such assistance.

If such a suspension occurs and you lose entitlement of such medical assistance, your policy is automatically reinstituted effective as of the date of termination of such entitlement if you provide notice of loss of such entitlement within 90 days after the date of such loss and pay the premiums attributable to the period. Your reinstituted policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this policy will be suspended for any period that may be provided by federal regulation at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan, as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and you lose coverage under the group health plan, your policy will be automatically reinstituted, effective as of the date of loss of such coverage, if you provide notice of loss of coverage within 90 days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of your coverage provides for:

- No waiting period with respect to treatment of pre-existing conditions.
- Coverage equivalent to the coverage in effect before the date of suspension.
- Your classification of premium to be as favorable to you as the premium classification terms that would have applied to you had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this policy, an extension of benefits will be granted for any continuous loss that commenced during a period where the policy was in force and the premium was paid. This extension of benefits beyond the period during which the policy was in force may be conditioned upon your continuous total disability, limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- Expenses incurred while this policy is not in force, except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- That portion of any expense incurred that is paid for by Medicare;
- Services for non-Medicare-Eligible Expenses, unless specifically covered in the policy, including but not limited to routine exams, take-home drugs, and eye refractions;
- Services for which a charge is not normally made in the absence of insurance;
- Loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this policy will be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for the policy will be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the two-year period.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium due after the initial premium. The policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due, and claims incurred on or after that date will not be considered for payment. A grace period does not apply if you cancel your policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by us for payment, a subsequent acceptance of any premium by us or by any of our authorized agents, without requiring an application for reinstatement, will reinstate the policy, provided, however, that if we or any of our authorized agents require an application for reinstatement and issue a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt, unless we have previously notified you in writing of our disapproval of such application. The reinstated policy will cover only loss resulting from Injury or Sickness beginning on or after the date of reinstatement. In all other respects the company and the insured will have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within 20 days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Aflac, Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLAIM FORMS: When we receive the notice, we will send you forms for filing proof of loss. If we do not send the forms within 15 working days after receiving written notice, our requirements will be met if we receive written proof of the event, and the type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within 90 days after the date the loss began or occurred. If it is not reasonably possible to give timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, we will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to you or to any health care provider to whom you have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at your death will be paid to your estate or to any health care providers to whom you have assigned benefits. If we fail to pay the benefits payable upon receipt of due written proof of loss, we will have 15 working days thereafter to mail you a letter or notice that states the reasons we have for failing to pay the claim, either in whole or in part, and that also gives you a written itemization of any documents or other information needed to process the claim or any portions thereof that are not being paid. When all of the listed documents or other information needed to process the claim have been received, we will then have 15 working days to process and either pay the claim or deny it, in whole or in part, giving you the reasons we may have for denying such claim or any portion thereof.

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes your claim

electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare-Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us, or your health care provider may submit it to us on your behalf.

PHYSICAL EXAMINATIONS: At our expense, we may have you examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity will be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the policy that, on its Policy Effective Date, is in conflict with the laws of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim will bind us, unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Aflac Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLERICAL ERROR: Clerical error on our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

MISSTATEMENT OF AGE : If your age has been misstated, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age .

PRO RATA REFUND: If we receive written proof of death that terminates coverage, we will refund that part of any premium you have paid that covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this policy at any time by written notice delivered or mailed to us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we will make a pro rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation, except as provided for under the Extension of Benefits provision.

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the Policy Effective Date shown in the Policy Schedule.

[

Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
WORLDWIDE HEADQUARTERS
[1932 Wynnton Road]
[Columbus, GA 31999]

DIRECT ALL INQUIRIES TO:
AFLAC MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
[P.O. Box 1553]
[Pensacola, Florida 32591]
[1.888.207.2078]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN F

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.
READ YOUR POLICY CAREFULLY.

This policy provides benefits to supplement the Hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this policy. The Named Insured shown in the Policy Schedule will be referred to as “you,” “your,” or “yours.” **American Family Life Assurance Company of Columbus,** a stock company, will be referred to as "we," "our," "us," or “Aflac.”

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare supplement insurance policy is based on your answers to the questions on your application. A copy of the application is attached. Omissions or misstatements on the application could cause your claim to be denied or your policy to be rescinded. If for any reason your answers are incorrect, please contact us immediately at our Medicare Supplement Administrative Office.

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this policy. The term of this policy begins at 12:01 a.m. Standard time, at the place where you reside, on the Policy Effective Date shown in the Policy Schedule. It ends at midnight, Standard time, at the place where you reside, on the day before your premium is due. The date your premium is due is determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule.

30-DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read your policy carefully. If for any reason you are not satisfied, you may return your policy to us within 30 days after receiving it. If returned, the policy will be void from its beginning, and any premium paid will be refunded, less any claims paid.

GUARANTEED-RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This policy is guaranteed-renewable as long as you live, provided you continue to pay premiums when due. At no time, while you continue your policy in force, may we place any restrictive riders on your coverage. Your *policy anniversary date* is the same month and day as the Policy Effective Date for each succeeding year this policy remains in force. The premium may change on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as underwriting class, state of issue, and your most recent ZIP Code of residence. We will give you at least 30 days’ advance written notice if a new table of rates is applicable to the policy.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION.
THIS IS A NONPARTICIPATING POLICY.

TABLE OF CONTENTS

POLICY SCHEDULE

INSURED:	**POLICY EFFECTIVE DATE:**
POLICY NUMBER:	**ISSUE AGE:**
SEX:	**STATE OF ISSUE:**
MODE AT ISSUE:	**MODAL PREMIUM:**
PREMIUM TERM:	**UNDERWRITING CLASS:**

****

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN F

DEFINITIONS

Benefit Period means the period as determined by Medicare, which begins on the date you are first confined in a Hospital. It ends following a period of 60 consecutive days during which you have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare-Eligible Expenses you have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a Hospital that is approved, or eligible to be approved, to receive payments from Medicare and that is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or **Hospitalization** means being confined in a Hospital on an inpatient basis.

Immediate Family means your spouse; parents; grandparents; children; or siblings and spouses, as applicable, of any of these.

Injury means a bodily Injury that is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of 60 extra days in the Hospital provided to you by Medicare. These reserve days must be used if you are Hospitalized for more than 90 days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days you have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with generally accepted standards or medical practice; and (4) not solely for the convenience of you or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare-Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Medicare Part B Deductible means the fixed amount you must pay each Calendar Year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount. A Calendar Year begins on January 1 and ends on December 31.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include you or any member of your Immediate Family.

Policy Effective Date means the effective date of this policy and is shown in the Policy Schedule. The Policy Effective Date is not the date you signed the application for coverage.

DEFINITIONS – CONTINUED

Sickness means illness or disease that first manifests itself after the Policy Effective Date and while this policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and operated within the scope and intent of its license. It does not include a facility or any of its sections that is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare-Eligible Expenses not paid by Medicare. Benefits are paid only to the extent specified in this provision.

The benefits paid under this policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare-Eligible Expenses for Hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

Coverage of Part A Medicare-Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Part A Medicare-Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider will accept our payment as payment in full and may not bill you for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare-Eligible Expenses under Part B, regardless of Hospital confinement, subject to the Medicare Part B Deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare-Eligible Expenses for hospice care and respite care expenses.

Additional Benefits for Plan F

Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

Medicare Part B Deductible: Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

Additional Benefits for Plan F – Continued

One Hundred Percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year deductible of $250 and a lifetime maximum benefit of $50,000.

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this policy will automatically change to reflect any changes that will become effective under Medicare deductibles, copayments, or Coinsurance Amounts. Only those provisions of the policy that are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on Page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this policy are suspended at your request for a period not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify us within 90 days after the day you become entitled to such assistance.

If such a suspension occurs and you lose entitlement of such medical assistance, your policy is automatically reinstituted effective as of the date of termination of such entitlement if you provide notice of loss of such entitlement within 90 days after the date of such loss and pay the premiums attributable to the period. Your reinstituted policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this policy will be suspended for any period that may be provided by federal regulation at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan, as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and you lose coverage under the group health plan, your policy will be automatically reinstituted, effective as of the date of loss of such coverage, if you provide notice of loss of coverage within 90 days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of your coverage provides for:

- No waiting period with respect to treatment of pre-existing conditions.
- Coverage equivalent to the coverage in effect before the date of suspension.
- Your classification of premium to be as favorable to you as the premium classification terms that would have applied to you had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this policy, an extension of benefits will be granted for any continuous loss that commenced during a period where the policy was in force and the premium was paid. This extension of benefits beyond the period during which the policy was in force may be conditioned upon your continuous total disability, limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- Expenses incurred while this policy is not in force, except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- That portion of any expense incurred that is paid for by Medicare;
- Services for non-Medicare-Eligible Expenses, unless specifically covered in the policy, including but not limited to routine exams, take-home drugs, and eye refractions;
- Services for which a charge is not normally made in the absence of insurance;
- Loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this policy will be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for the policy will be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the two-year period.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium due after the initial premium. The policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due, and claims incurred on or after that date will not be considered for payment. A grace period does not apply if you cancel your policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by us for payment, a subsequent acceptance of any premium by us or by any of our authorized agents, without requiring an application for reinstatement, will reinstate the policy, provided, however, that if we or any of our authorized agents require an application for reinstatement and issue a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt, unless we have previously notified you in writing of our disapproval of such application. The reinstated policy will cover only loss resulting from Injury or Sickness beginning on or after the date of reinstatement. In all other respects the company and the insured will have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within 20 days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Aflac, Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLAIM FORMS: When we receive the notice, we will send you forms for filing proof of loss. If we do not send the forms within 15 working days after receiving written notice, our requirements will be met if we receive written proof of the event, and the type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within 90 days after the date the loss began or occurred. If it is not reasonably possible to give timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, we will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to you or to any health care provider to whom you have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at your death will be paid to your estate or to any health care providers to whom you have assigned benefits. If we fail to pay the benefits payable upon receipt of due written proof of loss, we will have 15 working days thereafter to mail you a letter or notice that states the reasons we have for failing to pay the claim, either in whole or in part, and that also gives you a written itemization of any documents or other information needed to process the claim or any portions thereof that are not being paid. When all of the listed documents or other information needed to process the claim have been received, we will then have 15 working days to process and either pay the claim or deny it, in whole or in part, giving you the reasons we may have for denying such claim or any portion thereof.

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare-Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us, or your health care provider may submit it to us on your behalf.

PHYSICAL EXAMINATIONS: At our expense, we may have you examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity will be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the policy that, on its Policy Effective Date, is in conflict with the laws of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim will bind us, unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Aflac Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLERICAL ERROR: Clerical error on our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

MISSTATEMENT OF AGE : If your age has been misstated, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age .

PRO RATA REFUND: If we receive written proof of death that terminates coverage, we will refund that part of any premium you have paid that covers a period after death occurs.

GENERAL POLICY PROVISIONS – CONTINUED

CANCELLATION BY INSURED: You may cancel this policy at any time by written notice delivered or mailed to us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we will make a pro rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation, except as provided for under the Extension of Benefits provision.

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the Policy Effective Date shown in the Policy Schedule.

[ 

Paul S. Amos II, President Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
WORLDWIDE HEADQUARTERS
[1932 Wynnton Road]
[Columbus, GA 31999]

DIRECT ALL INQUIRIES TO:
AFLAC MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
[P.O. Box 1553]
[Pensacola, Florida 32591]
[1.888.207.2078]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN G

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.
READ YOUR POLICY CAREFULLY.

This policy provides benefits to supplement the Hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this policy. The Named Insured shown in the Policy Schedule will be referred to as “you,” “your,” or “yours.” **American Family Life Assurance Company of Columbus,** a stock company, will be referred to as "we," "our," "us," or “Aflac.”**NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

IMPORTANT NOTICE: Issuance of this Medicare supplement insurance policy is based on your answers to the questions on your application. A copy of the application is attached. Omissions or misstatements on the application could cause your claim to be denied or your policy to be rescinded. If for any reason your answers are incorrect, please contact us immediately at our Medicare Supplement Administrative Office.

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this policy. The term of this policy begins at 12:01 a.m. Standard time, at the place where you reside, on the Policy Effective Date shown in the Policy Schedule. It ends at midnight, Standard time, at the place where you reside, on the day before your premium is due. The date your premium is due is determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule.

30-DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read your policy carefully. If for any reason you are not satisfied, you may return your policy to us within 30 days after receiving it. If returned, the policy will be void from its beginning, and any premium paid will be refunded, less any claims paid.

GUARANTEED-RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This policy is guaranteed-renewable as long as you live, provided you continue to pay premiums when due. At no time, while you continue your policy in force, may we place any restrictive riders on your coverage. Your *policy anniversary date* is the same month and day as the Policy Effective Date for each succeeding year this policy remains in force. The premium may change on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as underwriting class, state of issue, and your most recent ZIP Code of residence. We will give you at least 30 days’ advance written notice if a new table of rates is applicable to the policy.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION.
THIS IS A NONPARTICIPATING POLICY.

TABLE OF CONTENTS

POLICY SCHEDULE

INSURED:	**POLICY EFFECTIVE DATE:**
POLICY NUMBER:	**ISSUE AGE:**
SEX:	**STATE OF ISSUE:**
MODE AT ISSUE:	**MODAL PREMIUM:**
PREMIUM TERM:	**UNDERWRITING CLASS:**

****

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN G

DEFINITIONS

Benefit Period means the period as determined by Medicare, which begins on the date you are first confined in a Hospital. It ends following a period of 60 consecutive days during which you have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare-Eligible Expenses you have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a Hospital that is approved, or eligible to be approved, to receive payments from Medicare and that is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or **Hospitalization** means being confined in a Hospital on an inpatient basis.

Immediate Family means your spouse; parents; grandparents; children; or siblings and spouses, as applicable, of any of these.

Injury means a bodily Injury that is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of 60 extra days in the Hospital provided to you by Medicare. These reserve days must be used if you are Hospitalized for more than 90 days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days you have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with generally accepted standards or medical practice; and (4) not solely for the convenience of you or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare-Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include you or any member of your Immediate Family.

Policy Effective Date means the effective date of this policy and is shown in the Policy Schedule. The Policy Effective Date is not the date you signed the application for coverage.

Sickness means illness or disease that first manifests itself after the Policy Effective Date and while this policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and operated within the scope and intent of its license. It does not include a facility or any of its sections that is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare-Eligible Expenses not paid by Medicare. Benefits are paid only to the extent specified in this provision.

The benefits paid under this policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare-Eligible Expenses for Hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

Coverage of Part A Medicare-Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Part A Medicare-Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider will accept our payment as payment in full and may not bill you for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare-Eligible Expenses under Part B, regardless of Hospital confinement, subject to the Medicare Part B Deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare-Eligible Expenses for hospice care and respite care expenses.

Additional Benefits for Plan G

Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

One Hundred Percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year deductible of $250 and a lifetime maximum benefit of $50,000.

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this policy will automatically change to reflect any changes that will become effective under Medicare deductibles, copayments, or Coinsurance Amounts. Only those provisions of the policy that are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on Page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this policy are suspended at your request for a period not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify us within 90 days after the day you become entitled to such assistance.

If such a suspension occurs and you lose entitlement of such medical assistance, your policy is automatically reinstituted effective as of the date of termination of such entitlement if you provide notice of loss of such entitlement within 90 days after the date of such loss and pay the premiums attributable to the period. Your reinstituted policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this policy will be suspended for any period that may be provided by federal regulation at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan, as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and you lose coverage under the group health plan, your policy will be automatically reinstituted, effective as of the date of loss of such coverage, if you provide notice of loss of coverage within 90 days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of your coverage provides for:

- No waiting period with respect to treatment of pre-existing conditions.
- Coverage equivalent to the coverage in effect before the date of suspension.
- Your classification of premium to be as favorable to you as the premium classification terms that would have applied to you had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this policy, an extension of benefits will be granted for any continuous loss that commenced during a period where the policy was in force and the premium was paid. This extension of benefits beyond the period during which the policy was in force may be conditioned upon your continuous total disability, limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- Expenses incurred while this policy is not in force, except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- That portion of any expense incurred that is paid for by Medicare;
- Services for non-Medicare-Eligible Expenses, unless specifically covered in the policy, including but not limited to routine exams, take-home drugs, and eye refractions;
- Services for which a charge is not normally made in the absence of insurance;
- Loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this policy will be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for the policy will be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the two-year period.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium due after the initial premium. The policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due, and claims incurred on or after that date will not be considered for payment. A grace period does not apply if you cancel your policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by us for payment, a subsequent acceptance of any premium by us or by any of our authorized agents, without requiring an application for reinstatement, will reinstate the policy, provided, however, that if we or any of our authorized agents require an application for reinstatement and issue a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt, unless we have previously notified you in writing of our disapproval of such application. The reinstated policy will cover only loss resulting from Injury or Sickness beginning on or after the date of reinstatement. In all other respects the company and the insured will have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within 20 days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Aflac, Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLAIM FORMS: When we receive the notice, we will send you forms for filing proof of loss. If we do not send the forms within 15 working days after receiving written notice, our requirements will be met if we receive written proof of the event, and the type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within 90 days after the date the loss began or occurred. If it is not reasonably possible to give timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, we will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to you or to any health care provider to whom you have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at your death will be paid to your estate or to any health care providers to whom you have assigned benefits. If we fail to pay the benefits payable upon receipt of due written proof of loss, we will have 15 working days thereafter to mail you a letter or notice that states the reasons we have for failing to pay the claim, either in whole or in part, and that also gives you a written itemization of any documents or other information needed to process the claim or any portions thereof that are not being paid. When all of the listed documents or other information needed to process the claim have been received, we will then have 15 working days to process and either pay the claim or deny it, in whole or in part, giving you the reasons we may have for denying such claim or any portion thereof.

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare-Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us, or your health care provider may submit it to us on your behalf.

PHYSICAL EXAMINATIONS: At our expense, we may have you examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity will be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the policy that, on its Policy Effective Date, is in conflict with the laws of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim will bind us, unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Aflac Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLERICAL ERROR: Clerical error on our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

MISSTATEMENT OF AGE : If your age has been misstated, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age .

PRO RATA REFUND: If we receive written proof of death that terminates coverage, we will refund that part of any premium you have paid that covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this policy at any time by written notice delivered or mailed to us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we will make a pro rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation, except as provided for under the Extension of Benefits provision.

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the Policy Effective Date shown in the Policy Schedule.

[

Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
WORLDWIDE HEADQUARTERS
[1932 Wynnton Road]
[Columbus, GA 31999]

DIRECT ALL INQUIRIES TO:
AFLAC MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
[P.O. Box 1553]
[Pensacola, Florida 32591]
[1.888.207.2078]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN N

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.
READ YOUR POLICY CAREFULLY.

This policy provides benefits to supplement the Hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this policy. The Named Insured shown in the Policy Schedule will be referred to as “you,” “your,” or “yours.” **American Family Life Assurance Company of Columbus,** a stock company, will be referred to as "we," "our," "us," or “Aflac.”

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare supplement insurance policy is based on your answers to the questions on your application. A copy of the application is attached. Omissions or misstatements on the application could cause your claim to be denied or your policy to be rescinded. If for any reason your answers are incorrect, please contact us immediately at our Medicare Supplement Administrative Office.

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this policy. The term of this policy begins at 12:01 a.m. Standard time, at the place where you reside, on the Policy Effective Date shown in the Policy Schedule. It ends at midnight, Standard time, at the place where you reside, on the day before your premium is due. The date your premium is due is determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule.

30-DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read your policy carefully. If for any reason you are not satisfied, you may return your policy to us within 30 days after receiving it. If returned, the policy will be void from its beginning, and any premium paid will be refunded, less any claims paid.

GUARANTEED-RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This policy is guaranteed-renewable as long as you live, provided you continue to pay premiums when due. At no time, while you continue your policy in force, may we place any restrictive riders on your coverage. Your *policy anniversary date* is the same month and day as the Policy Effective Date for each succeeding year this policy remains in force. The premium may change on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as underwriting class, state of issue, and your most recent ZIP Code of residence. We will give you at least 30 days’ advance written notice if a new table of rates is applicable to the policy.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION.
THIS IS A NONPARTICIPATING POLICY.

TABLE OF CONTENTS

POLICY SCHEDULE

INSURED:	**POLICY EFFECTIVE DATE:**
POLICY NUMBER:	**ISSUE AGE:**
SEX:	**STATE OF ISSUE:**
MODE AT ISSUE:	**MODAL PREMIUM:**
PREMIUM TERM:	**UNDERWRITING CLASS:**

****

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN N

DEFINITIONS

Benefit Period means the period as determined by Medicare, which begins on the date you are first confined in a Hospital. It ends following a period of 60 consecutive days during which you have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare-Eligible Expenses you have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a Hospital that is approved, or eligible to be approved, to receive payments from Medicare and that is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or **Hospitalization** means being confined in a Hospital on an inpatient basis.

Immediate Family means your spouse; parents; grandparents; children; or siblings and spouses, as applicable, of any of these.

Injury means a bodily Injury that is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of 60 extra days in the Hospital provided to you by Medicare. These reserve days must be used if you are Hospitalized for more than 90 days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days you have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with generally accepted standards or medical practice; and (4) not solely for the convenience of you or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare-Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Medicare Part B Deductible means the fixed amount you must pay each Calendar Year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount. A Calendar Year begins on January 1 and ends on December 31.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include you or any member of your Immediate Family.

Policy Copayment is the fixed amount the policy will not pay for specified Medicare Part B expenses after the Medicare Part B Deductible has been met. This Policy Copayment will change in accordance with applicable law and regulation. You are responsible to pay the Policy Copayments.

DEFINITIONS – CONTINUED

Policy Effective Date means the effective date of this policy and is shown in the Policy Schedule. The Policy Effective Date is not the date you signed the application for coverage.

Sickness means illness or disease that first manifests itself after the Policy Effective Date and while this policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and operated within the scope and intent of its license. It does not include a facility or any of its sections that is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare-Eligible Expenses not paid by Medicare. Benefits are paid only to the extent specified in this provision.

The benefits paid under this policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare-Eligible Expenses for Hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

Coverage of Part A Medicare-Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Part A Medicare-Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider will accept our payment as payment in full and may not bill you for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare-Eligible Expenses under Part B, regardless of Hospital confinement, subject to the Medicare Part B Deductible and copayment amounts described below. You are responsible to pay:

1. the lesser of the Policy Copayment or the Medicare Part B coinsurance/copayment for each covered health care provider office visit (including visits to medical specialists); and

2. the lesser of the Policy Copayment or the Medicare Part B coinsurance/copayment for each covered emergency room visit. The emergency room copayment will be waived if you are admitted to any Hospital and the emergency room visit is subsequently covered as a Medicare Part expense.

Hospice Care: Coverage of cost sharing for all Part A Medicare-Eligible Expenses for hospice care and respite care expenses.

Additional Benefits for Plan N

Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year deductible of $250 and a lifetime maximum benefit of $50,000.

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this policy will automatically change to reflect any changes that will become effective under Medicare deductibles, copayments, or Coinsurance Amounts. Only those provisions of the policy that are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on Page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this policy are suspended at your request for a period not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify us within 90 days after the day you become entitled to such assistance.

If such a suspension occurs and you lose entitlement of such medical assistance, your policy is automatically reinstituted effective as of the date of termination of such entitlement if you provide notice of loss of such entitlement within 90 days after the date of such loss and pay the premiums attributable to the period. Your reinstituted policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this policy will be suspended for any period that may be provided by federal regulation at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan, as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and you lose coverage under the group health plan, your policy will be automatically reinstituted, effective as of the date of loss of such coverage, if you provide notice of loss of coverage within 90 days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of your coverage provides for:

- No waiting period with respect to treatment of pre-existing conditions.
- Coverage equivalent to the coverage in effect before the date of suspension.
- Your classification of premium to be as favorable to you as the premium classification terms that would have applied to you had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this policy, an extension of benefits will be granted for any continuous loss that commenced during a period where the policy was in force and the premium was paid. This extension of benefits beyond the period during which the policy was in force may be conditioned upon your continuous total disability, limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- Expenses incurred while this policy is not in force, except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- That portion of any expense incurred that is paid for by Medicare;
- Services for non-Medicare-Eligible Expenses, unless specifically covered in the policy, including but not limited to routine exams, take-home drugs, and eye refractions;
- Services for which a charge is not normally made in the absence of insurance;
- Loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this policy will be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for the policy will be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the two-year period.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium due after the initial premium. The policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due, and claims incurred on or after that date will not be considered for payment. A grace period does not apply if you cancel your policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by us for payment, a subsequent acceptance of any premium by us or by any of our authorized agents, without requiring an application for reinstatement, will reinstate the policy, provided, however, that if we or any of our authorized agents require an application for reinstatement and issue a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt, unless we have previously notified you in writing of our disapproval of such application. The reinstated policy will cover only loss resulting from Injury or Sickness beginning on or after the date of reinstatement. In all other respects the company and the insured will have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within 20 days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Aflac, Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

GENERAL POLICY PROVISIONS – CONTINUED

CLAIM FORMS: When we receive the notice, we will send you forms for filing proof of loss. If we do not send the forms within 15 working days after receiving written notice, our requirements will be met if we receive written proof of the event, and the type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within 90 days after the date the loss began or occurred. If it is not reasonably possible to give timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, we will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to you or to any health care provider to whom you have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at your death will be paid to your estate or to any health care providers to whom you have assigned benefits. If we fail to pay the benefits payable upon receipt of due written proof of loss, we will have 15 working days thereafter to mail you a letter or notice that states the reasons we have for failing to pay the claim, either in whole or in part, and that also gives you a written itemization of any documents or other information needed to process the claim or any portions thereof that are not being paid. When all of the listed documents or other information needed to process the claim have been received, we will then have 15 working days to process and either pay the claim or deny it, in whole or in part, giving you the reasons we may have for denying such claim or any portion thereof.

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare-Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us, or your health care provider may submit it to us on your behalf.

PHYSICAL EXAMINATIONS: At our expense, we may have you examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity will be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the policy that, on its Policy Effective Date, is in conflict with the laws of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim will bind us, unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Aflac Medicare Supplement Claims Processing Center, [P.O. Box 1553, Pensacola, Florida 32591].

CLERICAL ERROR: Clerical error on our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

GENERAL POLICY PROVISIONS – CONTINUED

MISSTATEMENT OF AGE : If your age has been misstated, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age .

PRO RATA REFUND: If we receive written proof of death that terminates coverage, we will refund that part of any premium you have paid that covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this policy at any time by written notice delivered or mailed to us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we will make a pro rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation, except as provided for under the Extension of Benefits provision.

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the Policy Effective Date shown in the Policy Schedule.

[Paul S. Amos II, President Joey M. Loudermilk, Secretary]

Application for Medicare Supplement Insurance (A19MS Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999
Administration: [P.O. Box 1553]
[Pensacola, Fl 32591]

SECTION A. PROPOSED INSURED INFORMATION

Applicant Name *(exactly as it appears on your Medicare card)* Male ☐ Female ☐	
Street Address	City, State, ZIP Code
Mailing Address *(if different from street address)*	City, State, ZIP Code
Phone *(with area code)*	Email Address *(optional)*
Date of Birth *(mm/dd/yyyy)*	Current Age
Medicare Card No.	Social Security No.
Height (*feet and inches)*	Weight *(pounds)*

SECTION B. PLAN AND PREMIUM INFORMATION

You may be eligible for a policy with a lower premium rate based on your answer to the following questions:

Household does not include any type of licensed facility that provides care.

Does a member of your household with whom you have continuously resided for the last 12 months have an existing Medicare supplement policy with Aflac? Yes ☐ No ☐

Or

Is a member of your household with whom you have continuously resided for the last 12 months applying for a Medicare supplement policy with Aflac? Yes ☐ No ☐

If you answered "yes" to either question above, please provide the following information for that household member:

Name *(exactly as it appears on Medicare card)*

Medicare Card No.

Aflac Policy Number, if applicable

Plan – *(You Are Currently Applying For)*	Requested Policy Effective Date
Premium $	Premium Collected $

Payment Method: Bank Draft ☐ Direct Bill ☐

Payment Mode: Monthly ☐ *(Bank Draft ONLY)* Annual ☐ Semiannual ☐ Quarterly ☐

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Are you covered under Medicare Part A? Yes ☐ No ☐
   If yes, what is your Part A effective date? / /
   If no, what is your eligibility date? / /
2. Are you covered under Medicare Part B? Yes ☐ No ☐
   If yes, what is your Part B effective date? / /
   If no, what is your eligibility date? / /
3. Are you applying during a guaranteed-issue period? (If yes, please attach proof of eligibility.) Yes ☐ No ☐
4. If you are currently on Medicare Disability, are you eligible for Medicare due to disability or end-stage renal disease (ESRD)? Yes ☐ No ☐

   IF yes, please check the box that applies. ☐ Disability ☐ End-Stage Renal Disease (ESRD)

SECTION D. HEALTH QUESTIONS

If applying during open enrollment or a guaranteed-issue period, go to **SECTION F**.

If not, **PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS**. If you answer yes to any of the following Questions 1–7, you are not eligible for coverage.

1. Have you used tobacco in any form in the past 12 months? Yes ☐ No ☐
2. Are you currently hospitalized, confined to a nursing facility, receiving the services of a home health agency, bedridden, or do you require the use of a wheel chair or motorized mobility aid? Yes ☐ No ☐
3. Are you now receiving, or have you ever received medical advice or treatment for, been advised to have treatment or surgery for, or taken medication for any of the following conditions:
   A. Emphysema, chronic obstructive pulmonary disease (COPD), sarcoidosis, scleroderma, chronic pulmonary disorders, or any chronic pulmonary disease requiring the use of oxygen? Yes ☐ No ☐
   B. Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis, hepatitis C, or kidney disease? Yes ☐ No ☐
   C. Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes ☐ No ☐
   D. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? Yes ☐ No ☐
   E. Diabetes with peripheral vascular disease, neuropathy, any type heart condition, kidney disease, retinopathy, or high blood pressure? Yes ☐ No ☐
4. Are you now receiving, or in the last three years have you received medical advice or treatment for, been advised to have treatment or surgery for, or taken medication for any of the following conditions:
   A. Cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma? Yes ☐ No ☐

B. Ulcerative colitis or Crohn's disease? Yes ☐ No ☐
C. Alcoholism or drug abuse? Yes ☐ No ☐
D. Joint replacement? Yes ☐ No ☐
E. Heart attack, heart disease, coronary artery disease, cardiomyopathy, enlarged heart, stroke, transient ischemic attacks (TIA)? Yes ☐ No ☐
F. Congestive heart failure, peripheral vascular disease, heart valve disease, carotid artery disease (not including high blood pressure), heart rhythm disorders? Yes ☐ No ☐
G. Any amputation caused by disease? Yes ☐ No ☐
H. Degenerative bone disease, or rheumatoid or disabling arthritis? Yes ☐ No ☐
I. Major depression, bi-polar disorder, schizophrenia, a paranoid disorder, or any other mental or nervous disorder requiring psychiatric care? Yes ☐ No ☐
J. Diabetes treated with insulin or other injectables? Yes ☐ No ☐

5. Have you been advised by a physician that surgery may be required within 12 months for cataracts? Yes ☐ No ☐

6. In the last three years, have you been advised by a physician to have surgery, medical tests, treatment, or therapy that has not been performed? Yes ☐ No ☐

7. In the last two years, have you been hospitalized three or more times, received home health care three or more times, or been confined to a nursing facility for more than 30 days? Yes ☐ No ☐

8. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes ☐ No ☐

SECTION E. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes ☐ No ☐
If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

SECTION F. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requires that we ask the following questions about insurance policies or certificates you may have.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your previous insurer with your application.
PLEASE ANSWER ALL QUESTIONS.

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes ☐ No ☐

   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐

   (c) If yes, indicate your effective date. / /

2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐

   (NOTE TO APPLICANT: If you are participating in a spend-down program and have not met your share of cost, please answer no to the above question.)
   If yes, answer (a) and (b) below.

   (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? Yes ☐ No ☐

   If yes, answer (a)–(g) below.

   (a) Name of Company

   Plan Type & Policy/Certificate No.

   Company Telephone No.

   Coverage Dates: START DATE / /

   (If you are still covered under this plan, leave end date blank.) END DATE / /

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes ☐ No ☐

   If yes, have you received a copy of the replacement notice? Yes ☐ No ☐

   (c) Reason for termination/disenrollment:

   (d) Planned date of termination/disenrollment: / /

   (e) Was this your first time participating in this type of Medicare plan? Yes ☐ No ☐

   (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐

   (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes ☐ No ☐

   If yes, answer (a)–(d) below.

(a) Name of Company

Plan Type & Policy/Certificate No.

Company Telephone No.

Issue Date / /

(b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes ☐ No ☐

(c) Indicate termination date. / /

(d) Have you received a copy of the replacement notice? Yes ☐ No ☐

5. Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual non-Medicare supplement plan) Yes ☐ No ☐

If yes, answer (a)–(c) below.

(a) Name of Company

Plan Type & Policy/Certificate No.

Company Telephone No.

Coverage Dates: START DATE / /

(If you are still covered under this plan, leave end date blank.) END DATE / /

(b) Reason for termination or disenrollment:

(c) Planned date of termination/disenrollment: / /

Do you or your spouse have other coverage with Aflac? Yes ☐ No ☐

This section to be completed only by an agent, if applicable.

Agents will list any other health insurance policies they have sold to the applicant.

1. List policies sold that are still in force.

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

2. List policies sold in the past five years that are no longer in force.
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement insurance policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare supplement insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB Inc. (formerly known as the Medical Information Bureau), a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or submit a claim for benefits to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at mib.com.

I request that a copy of my application, outline of coverage and premium rate be provided to my advisor (lawyer, financial consultant or my closest relative, etc.). (If you do not wish to name an advisor, so state on the lines below):

Last Name First Name MI ( ) Phone

Street/P.O. Box City State ZIP Code

Protection Against Unintended Lapse (Optional)

I request that a notice of cancellation for nonpayment of premium be provided to the person designated below.

Last Name First Name MI

Street/P.O. Box

City State ZIP Code

I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this Medicare supplement insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive this notice.

Proposed Insured's Signature: X _____ Date _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an outline of coverage for the policy applied for, and (b) a *Guide to Health Insurance for People with Medicare*.

Signed at: _____ _____ _____

State Applicant's Signature Date

Signed at: _____ _____ _____

State Agent's Signature and Writing Number Date

[**Policy Mailing Preference:**

I prefer to receive an electronic copy of my policy instead of a paper copy. If your answer is yes, please enter your email address on Page 1. ❑ Yes ❑ No]

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE [1.888.207.2078].
VISIT OUR WEB SITE AT AFLAC.COM.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

Outline of Medicare Supplement Coverage

Benefit Plans A, C, D, F, G and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.**
- **Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.**
- **Blood – First three pints of blood each year.**
- **Hospice – Part A coinsurance**

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100 % Part B coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100 %)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out- of-pocket limit $[4660] paid at 100% after limit reached	Out-of -Pocket limit $[2330] paid at 100% after limit reached		

***Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[2070]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

INSERT RATE PAGES

PREMIUM INFORMATION

American Family Life Assurance Company of Columbus may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as underwriting class, state of issue, and your most recent ZIP code of residence.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and American Family Life Assurance Company of Columbus.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: American Family Life Assurance Company of Columbus, Medicare Supplement Administration, [P.O. Box 1553, Pensacola, Florida 32591]. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This Policy may not fully cover all of your medical costs. Neither American Family Life Assurance Company of Columbus nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. American Family Life Assurance Company of Columbus may cancel your Policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your Policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1156]	$0	$[1156] (Part A deductible)
61st thru 90th day	All but $[289] a day	$[289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[578] a day	$[578] a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[144.50] a day	$0	Up to $[144.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1156]	$[1156] (Part A deductible)	$0
61st thru 90th day	All but $[289] a day	$[289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[578] a day	$[578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[144.50] a day	Up to $[144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[140] of Medicare Approved Amounts*	$0	$[140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[140] of Medicare Approved Amounts*	$0	$[140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $[140] of Medicare Approved Amounts*	$0	$[140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends afte
have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1156]	$[1156] (Part A deductible)	$0
61st thru 90th day	All but $[289] a day	$[289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[578] a day	$[578] a day	$0
— Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[144.50] a day	Up to $[144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

TICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of
care and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided
e policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based
ny difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $[140] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $[140] (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1156]	$[1156] (Part A deductible)	$0
61st thru 90th day	All but $[289] a day	$[289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[578] a day	$[578] a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[144.50] a day	Up to $[144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[140] of Medicare Approved Amounts*	$0	$[140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[140] of Medicare Approved amounts*	$0	$[140] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment First $[140] of Medicare Approved Amounts*	$0	$[140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1156]	$[1156] (Part A deductible)	$0
61st thru 90th day	All but $[289] a day	$[289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[578] a day	$[578] a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[144.50] a day	Up to $[144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed $[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $[140] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $[140] (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends afte have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1156]	$[1156] (Part A deductible)	$0
61st thru 90th day	All but $[289] a day	$[289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[578] a day	$[578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[144.50] a day	Up to $[144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

TICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of care and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided e policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based ny difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[140] of Medicare Approved Amounts*	$0	$0	$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $[140] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $[140] (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
WORLDWIDE HEADQUARTERS
[1932 Wynnton Road]
[Columbus, GA 31999]

DIRECT ALL INQUIRIES TO:
AFLAC MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
[P.O. Box 1553]
[Pensacola, Fl 32591]
[1.888.207.2078]

AMENDMENT TO APPLICATION

I hereby agree that the following changes noted below shall be an amendment to and form a part of the application for Policy Number _____ and shall be binding on any person who shall have or claim any interest under such policy.

Acceptance is acknowledged by:

_____ _____
Insured Date

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the Policy Effective Date shown in the Policy Schedule.

[ 

Paul S. Amos II, President Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
WORLDWIDE HEADQUARTERS
[1932 Wynnton Road]
[Columbus, GA 31999]

DIRECT ALL INQUIRIES TO:

AFLAC MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
[P.O. Box 13547]
[Pensacola, Fl 32591]
[1.888.207.2078]

APPLICATION FOR REINSTATEMENT

I, _____, hereby apply for reinstatement of my policy number _____.

1. **To the best of your knowledge and belief, have you had any illness or personal injury, or consulted with, been prescribed for, operated on, or treated by any physician or other person during the past two years?**

   ☐ **Yes** ☐ **No If your answer is "Yes" give details as follows:**

Nature of Sickness, Disease	Dates of Each Occurrence From - To	Surgery Yes/No	Degree of Recovery	Hospitalized Yes/No	Hospital Name & Address If Confined (or Physician if not confined)

2. **Name and address of your family physician:** _____

_____

_____

I hereby reaffirm the correctness of the answers to the questions in my original application for the above-numbered policy, and I hereby represent that I am in good health and free from injury. I agree that if this policy is reinstated, such reinstatement shall be in accordance with the terms of the policy and shall not take effect until this application for reinstatement and the premium payment accompanying this application have been accepted and approved by the company.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant _____

Signed at _____ On _____
City State Month Day Year

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
WORLDWIDE HEADQUARTERS
[Columbus, GA 31999]

Aflac Medicare Supplement Administrative Office:
[P. O. Box 1553 Pensacola, Florida 32591]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Aflac. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Agent, Broker or Other Representative

_____
Name and Address of Agent

The above “Notice to Applicant” was delivered to me on:

_____ _____
Applicant’s Signature Date

REQUEST FOR CHANGE
American Family Life Assurance Company of Columbus
Worldwide Headquarters • Columbus, Georgia 31999
Administration: [P.O. Box 1553]
[Pensacola, Florida 32591]

Name of Policyholder _____
Last Name First Name MI

SSN _____ Policy Number _____

Policy Type _____ Date of Birth _____

Policyholder's E-Mail Address _____

Associate's/Agent's Signature _____ Writing Number _____
Licensed Resident Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY.

❑ **ADDRESS CHANGE ONLY**

New Address of Policyholder _____
Street Apt. No.

City _____ State _____ ZIP _____ Telephone No. _____

Former Address of Policyholder _____
Street Apt. No.

City _____ State _____ ZIP _____

❑ **NAME CHANGE ONLY**

Name Shown on Policy _____
Last Name First Name MI Title

Change Name To _____
Last Name First Name MI Title

Reason ❑ Marriage ❑ Divorce ❑ Death ❑ Request

Billing Name _____
(If policy is on payroll/association)

Draftee/Cardholder Name _____
(If policy is on bank draft/credit card)

Effective Date of Change _____

❑ **MEDICARE SUPPLEMENT DOWNGRADES ONLY**

Current Plan _____ New Plan _____

_____

Policyholder's Name (Please Print) Date

Policyholder's Signature _____ Date _____

SERFF Tracking #:	*FRCS-128603622*	***State Tracking #:***		***Company Tracking #:***	*5786*

State:	*Arkansas*	***Filing Company:***	*American Family Life Assurance Company of Columbus*
TOI/Sub-TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*		
Product Name:	*Medicare Supplement Filing*		
Project Name/Number:	*AFLAC/61/61*		

Rate Information

Rate data applies to filing.

Filing Method:	For Approval
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
American Family Life Assurance Company of Columbus	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*FRCS-128603622*	***State Tracking #:***		***Company Tracking #:***	*5786*

State:	*Arkansas*	***Filing Company:***	*American Family Life Assurance Company of Columbus*
TOI/Sub-TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*		
Product Name:	*Medicare Supplement Filing*		
Project Name/Number:	*AFLAC/61/61*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action*	Rate Action Information	Attachments
1	Approved-Closed 08/21/2012	Rates	A19MSARAR, A19MSCRAR, A19MSDRAR, A19MSFRAR, A19MSGRAR, A19MSNRAR	New		AR Rates (2).pdf

American Family Life Assurance Company of Columbus (Aflac)
State of Arkansas
Plan A

	Non-Tobacco User		Tobacco User	
Attained Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,526.88	1,526.88	1,755.96	1,755.96
66	1,526.88	1,526.88	1,755.96	1,755.96
67	1,526.88	1,526.88	1,755.96	1,755.96
68	1,526.88	1,526.88	1,755.96	1,755.96
69	1,526.88	1,526.88	1,755.96	1,755.96
70	1,526.88	1,526.88	1,755.96	1,755.96
71	1,526.88	1,526.88	1,755.96	1,755.96
72	1,526.88	1,526.88	1,755.96	1,755.96
73	1,526.88	1,526.88	1,755.96	1,755.96
74	1,526.88	1,526.88	1,755.96	1,755.96
75	1,526.88	1,526.88	1,755.96	1,755.96
76	1,526.88	1,526.88	1,755.96	1,755.96
77	1,526.88	1,526.88	1,755.96	1,755.96
78	1,526.88	1,526.88	1,755.96	1,755.96
79	1,526.88	1,526.88	1,755.96	1,755.96
80	1,526.88	1,526.88	1,755.96	1,755.96
81	1,526.88	1,526.88	1,755.96	1,755.96
82	1,526.88	1,526.88	1,755.96	1,755.96
83	1,526.88	1,526.88	1,755.96	1,755.96
84	1,526.88	1,526.88	1,755.96	1,755.96
85	1,526.88	1,526.88	1,755.96	1,755.96
86	1,526.88	1,526.88	1,755.96	1,755.96
87	1,526.88	1,526.88	1,755.96	1,755.96
88	1,526.88	1,526.88	1,755.96	1,755.96
89	1,526.88	1,526.88	1,755.96	1,755.96
90	1,526.88	1,526.88	1,755.96	1,755.96
91	1,526.88	1,526.88	1,755.96	1,755.96
92	1,526.88	1,526.88	1,755.96	1,755.96
93	1,526.88	1,526.88	1,755.96	1,755.96
94	1,526.88	1,526.88	1,755.96	1,755.96
95	1,526.88	1,526.88	1,755.96	1,755.96
96	1,526.88	1,526.88	1,755.96	1,755.96
97	1,526.88	1,526.88	1,755.96	1,755.96
98	1,526.88	1,526.88	1,755.96	1,755.96
99	1,526.88	1,526.88	1,755.96	1,755.96

[1] If the insured qualifies for household discount, the 7% discount will be applied.
[2] For payment made on monthly EBT, there is an additional $2 discount per month.
[3] Open enrollees and individuals with guaranteed issue rights will be offered non-tobacco rates.

Area Factors

3-Digit Zip Code	Factor
720-722	1.02
716-719, 723-729	0.88
Rest of State	1.02

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

American Family Life Assurance Company of Columbus (Aflac)
State of Arkansas
Plan C

	Non-Tobacco User		Tobacco User	
Attained Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,962.24	1,962.24	2,256.60	2,256.60
66	1,962.24	1,962.24	2,256.60	2,256.60
67	1,962.24	1,962.24	2,256.60	2,256.60
68	1,962.24	1,962.24	2,256.60	2,256.60
69	1,962.24	1,962.24	2,256.60	2,256.60
70	1,962.24	1,962.24	2,256.60	2,256.60
71	1,962.24	1,962.24	2,256.60	2,256.60
72	1,962.24	1,962.24	2,256.60	2,256.60
73	1,962.24	1,962.24	2,256.60	2,256.60
74	1,962.24	1,962.24	2,256.60	2,256.60
75	1,962.24	1,962.24	2,256.60	2,256.60
76	1,962.24	1,962.24	2,256.60	2,256.60
77	1,962.24	1,962.24	2,256.60	2,256.60
78	1,962.24	1,962.24	2,256.60	2,256.60
79	1,962.24	1,962.24	2,256.60	2,256.60
80	1,962.24	1,962.24	2,256.60	2,256.60
81	1,962.24	1,962.24	2,256.60	2,256.60
82	1,962.24	1,962.24	2,256.60	2,256.60
83	1,962.24	1,962.24	2,256.60	2,256.60
84	1,962.24	1,962.24	2,256.60	2,256.60
85	1,962.24	1,962.24	2,256.60	2,256.60
86	1,962.24	1,962.24	2,256.60	2,256.60
87	1,962.24	1,962.24	2,256.60	2,256.60
88	1,962.24	1,962.24	2,256.60	2,256.60
89	1,962.24	1,962.24	2,256.60	2,256.60
90	1,962.24	1,962.24	2,256.60	2,256.60
91	1,962.24	1,962.24	2,256.60	2,256.60
92	1,962.24	1,962.24	2,256.60	2,256.60
93	1,962.24	1,962.24	2,256.60	2,256.60
94	1,962.24	1,962.24	2,256.60	2,256.60
95	1,962.24	1,962.24	2,256.60	2,256.60
96	1,962.24	1,962.24	2,256.60	2,256.60
97	1,962.24	1,962.24	2,256.60	2,256.60
98	1,962.24	1,962.24	2,256.60	2,256.60
99	1,962.24	1,962.24	2,256.60	2,256.60

[1] If the insured qualifies for household discount, the 7% discount will be applied.
[2] For payment made on monthly EBT, there is an additional $2 discount per month.
[3] Open enrollees and individuals with guaranteed issue rights will be offered non-tobacco rates.

Area Factors

3-Digit Zip Code	Factor
720-722	1.02
716-719, 723-729	0.88
Rest of State	1.02

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

American Family Life Assurance Company of Columbus (Aflac)
State of Arkansas
Plan D

	Non-Tobacco User		Tobacco User	
Attained Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,775.16	1,775.16	2,041.44	2,041.44
66	1,775.16	1,775.16	2,041.44	2,041.44
67	1,775.16	1,775.16	2,041.44	2,041.44
68	1,775.16	1,775.16	2,041.44	2,041.44
69	1,775.16	1,775.16	2,041.44	2,041.44
70	1,775.16	1,775.16	2,041.44	2,041.44
71	1,775.16	1,775.16	2,041.44	2,041.44
72	1,775.16	1,775.16	2,041.44	2,041.44
73	1,775.16	1,775.16	2,041.44	2,041.44
74	1,775.16	1,775.16	2,041.44	2,041.44
75	1,775.16	1,775.16	2,041.44	2,041.44
76	1,775.16	1,775.16	2,041.44	2,041.44
77	1,775.16	1,775.16	2,041.44	2,041.44
78	1,775.16	1,775.16	2,041.44	2,041.44
79	1,775.16	1,775.16	2,041.44	2,041.44
80	1,775.16	1,775.16	2,041.44	2,041.44
81	1,775.16	1,775.16	2,041.44	2,041.44
82	1,775.16	1,775.16	2,041.44	2,041.44
83	1,775.16	1,775.16	2,041.44	2,041.44
84	1,775.16	1,775.16	2,041.44	2,041.44
85	1,775.16	1,775.16	2,041.44	2,041.44
86	1,775.16	1,775.16	2,041.44	2,041.44
87	1,775.16	1,775.16	2,041.44	2,041.44
88	1,775.16	1,775.16	2,041.44	2,041.44
89	1,775.16	1,775.16	2,041.44	2,041.44
90	1,775.16	1,775.16	2,041.44	2,041.44
91	1,775.16	1,775.16	2,041.44	2,041.44
92	1,775.16	1,775.16	2,041.44	2,041.44
93	1,775.16	1,775.16	2,041.44	2,041.44
94	1,775.16	1,775.16	2,041.44	2,041.44
95	1,775.16	1,775.16	2,041.44	2,041.44
96	1,775.16	1,775.16	2,041.44	2,041.44
97	1,775.16	1,775.16	2,041.44	2,041.44
98	1,775.16	1,775.16	2,041.44	2,041.44
99	1,775.16	1,775.16	2,041.44	2,041.44

[1] If the insured qualifies for household discount, the 7% discount will be applied.
[2] For payment made on monthly EBT, there is an additional $2 discount per month.
[3] Open enrollees and individuals with guaranteed issue rights will be offered non-tobacco rates.

Area Factors

3-Digit Zip Code	Factor
720-722	1.02
716-719, 723-729	0.88
Rest of State	1.02

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

American Family Life Assurance Company of Columbus (Aflac)
State of Arkansas
Plan F

	Non-Tobacco User		Tobacco User	
Attained Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	2,006.88	2,006.88	2,307.84	2,307.84
66	2,006.88	2,006.88	2,307.84	2,307.84
67	2,006.88	2,006.88	2,307.84	2,307.84
68	2,006.88	2,006.88	2,307.84	2,307.84
69	2,006.88	2,006.88	2,307.84	2,307.84
70	2,006.88	2,006.88	2,307.84	2,307.84
71	2,006.88	2,006.88	2,307.84	2,307.84
72	2,006.88	2,006.88	2,307.84	2,307.84
73	2,006.88	2,006.88	2,307.84	2,307.84
74	2,006.88	2,006.88	2,307.84	2,307.84
75	2,006.88	2,006.88	2,307.84	2,307.84
76	2,006.88	2,006.88	2,307.84	2,307.84
77	2,006.88	2,006.88	2,307.84	2,307.84
78	2,006.88	2,006.88	2,307.84	2,307.84
79	2,006.88	2,006.88	2,307.84	2,307.84
80	2,006.88	2,006.88	2,307.84	2,307.84
81	2,006.88	2,006.88	2,307.84	2,307.84
82	2,006.88	2,006.88	2,307.84	2,307.84
83	2,006.88	2,006.88	2,307.84	2,307.84
84	2,006.88	2,006.88	2,307.84	2,307.84
85	2,006.88	2,006.88	2,307.84	2,307.84
86	2,006.88	2,006.88	2,307.84	2,307.84
87	2,006.88	2,006.88	2,307.84	2,307.84
88	2,006.88	2,006.88	2,307.84	2,307.84
89	2,006.88	2,006.88	2,307.84	2,307.84
90	2,006.88	2,006.88	2,307.84	2,307.84
91	2,006.88	2,006.88	2,307.84	2,307.84
92	2,006.88	2,006.88	2,307.84	2,307.84
93	2,006.88	2,006.88	2,307.84	2,307.84
94	2,006.88	2,006.88	2,307.84	2,307.84
95	2,006.88	2,006.88	2,307.84	2,307.84
96	2,006.88	2,006.88	2,307.84	2,307.84
97	2,006.88	2,006.88	2,307.84	2,307.84
98	2,006.88	2,006.88	2,307.84	2,307.84
99	2,006.88	2,006.88	2,307.84	2,307.84

[1] If the insured qualifies for household discount, the 7% discount will be applied.
[2] For payment made on monthly EBT, there is an additional $2 discount per month.
[3] Open enrollees and individuals with guaranteed issue rights will be offered non-tobacco rates.

Area Factors

3-Digit Zip Code	Factor
720-722	1.02
716-719, 723-729	0.88
Rest of State	1.02

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

American Family Life Assurance Company of Columbus (Aflac)

State of Arkansas

Plan G

	Non-Tobacco User		Tobacco User	
Attained Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,817.04	1,817.04	2,089.56	2,089.56
66	1,817.04	1,817.04	2,089.56	2,089.56
67	1,817.04	1,817.04	2,089.56	2,089.56
68	1,817.04	1,817.04	2,089.56	2,089.56
69	1,817.04	1,817.04	2,089.56	2,089.56
70	1,817.04	1,817.04	2,089.56	2,089.56
71	1,817.04	1,817.04	2,089.56	2,089.56
72	1,817.04	1,817.04	2,089.56	2,089.56
73	1,817.04	1,817.04	2,089.56	2,089.56
74	1,817.04	1,817.04	2,089.56	2,089.56
75	1,817.04	1,817.04	2,089.56	2,089.56
76	1,817.04	1,817.04	2,089.56	2,089.56
77	1,817.04	1,817.04	2,089.56	2,089.56
78	1,817.04	1,817.04	2,089.56	2,089.56
79	1,817.04	1,817.04	2,089.56	2,089.56
80	1,817.04	1,817.04	2,089.56	2,089.56
81	1,817.04	1,817.04	2,089.56	2,089.56
82	1,817.04	1,817.04	2,089.56	2,089.56
83	1,817.04	1,817.04	2,089.56	2,089.56
84	1,817.04	1,817.04	2,089.56	2,089.56
85	1,817.04	1,817.04	2,089.56	2,089.56
86	1,817.04	1,817.04	2,089.56	2,089.56
87	1,817.04	1,817.04	2,089.56	2,089.56
88	1,817.04	1,817.04	2,089.56	2,089.56
89	1,817.04	1,817.04	2,089.56	2,089.56
90	1,817.04	1,817.04	2,089.56	2,089.56
91	1,817.04	1,817.04	2,089.56	2,089.56
92	1,817.04	1,817.04	2,089.56	2,089.56
93	1,817.04	1,817.04	2,089.56	2,089.56
94	1,817.04	1,817.04	2,089.56	2,089.56
95	1,817.04	1,817.04	2,089.56	2,089.56
96	1,817.04	1,817.04	2,089.56	2,089.56
97	1,817.04	1,817.04	2,089.56	2,089.56
98	1,817.04	1,817.04	2,089.56	2,089.56
99	1,817.04	1,817.04	2,089.56	2,089.56

[1] If the insured qualifies for household discount, the 7% discount will be applied.
[2] For payment made on monthly EBT, there is an additional $2 discount per month.
[3] Open enrollees and individuals with guaranteed issue rights will be offered non-tobacco rates.

Area Factors

3-Digit Zip Code	Factor
720-722	1.02
716-719, 723-729	0.88
Rest of State	1.02

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

American Family Life Assurance Company of Columbus (Aflac)
State of Arkansas
Plan N

	Non-Tobacco User		Tobacco User	
Attained Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,399.32	1,399.32	1,609.20	1,609.20
66	1,399.32	1,399.32	1,609.20	1,609.20
67	1,399.32	1,399.32	1,609.20	1,609.20
68	1,399.32	1,399.32	1,609.20	1,609.20
69	1,399.32	1,399.32	1,609.20	1,609.20
70	1,399.32	1,399.32	1,609.20	1,609.20
71	1,399.32	1,399.32	1,609.20	1,609.20
72	1,399.32	1,399.32	1,609.20	1,609.20
73	1,399.32	1,399.32	1,609.20	1,609.20
74	1,399.32	1,399.32	1,609.20	1,609.20
75	1,399.32	1,399.32	1,609.20	1,609.20
76	1,399.32	1,399.32	1,609.20	1,609.20
77	1,399.32	1,399.32	1,609.20	1,609.20
78	1,399.32	1,399.32	1,609.20	1,609.20
79	1,399.32	1,399.32	1,609.20	1,609.20
80	1,399.32	1,399.32	1,609.20	1,609.20
81	1,399.32	1,399.32	1,609.20	1,609.20
82	1,399.32	1,399.32	1,609.20	1,609.20
83	1,399.32	1,399.32	1,609.20	1,609.20
84	1,399.32	1,399.32	1,609.20	1,609.20
85	1,399.32	1,399.32	1,609.20	1,609.20
86	1,399.32	1,399.32	1,609.20	1,609.20
87	1,399.32	1,399.32	1,609.20	1,609.20
88	1,399.32	1,399.32	1,609.20	1,609.20
89	1,399.32	1,399.32	1,609.20	1,609.20
90	1,399.32	1,399.32	1,609.20	1,609.20
91	1,399.32	1,399.32	1,609.20	1,609.20
92	1,399.32	1,399.32	1,609.20	1,609.20
93	1,399.32	1,399.32	1,609.20	1,609.20
94	1,399.32	1,399.32	1,609.20	1,609.20
95	1,399.32	1,399.32	1,609.20	1,609.20
96	1,399.32	1,399.32	1,609.20	1,609.20
97	1,399.32	1,399.32	1,609.20	1,609.20
98	1,399.32	1,399.32	1,609.20	1,609.20
99	1,399.32	1,399.32	1,609.20	1,609.20

[1] If the insured qualifies for household discount, the 7% discount will be applied.
[2] For payment made on monthly EBT, there is an additional $2 discount per month.
[3] Open enrollees and individuals with guaranteed issue rights will be offered non-tobacco rates.

Area Factors

3-Digit Zip Code	Factor
720-722	1.02
716-719, 723-729	0.88
Rest of State	1.02

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

SERFF Tracking #:	*FRCS-128603622*	***State Tracking #:***	***Company Tracking #:*** *5786*

State:	*Arkansas*	***Filing Company:***	*American Family Life Assurance Company of Columbus*
TOI/Sub-TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*		
Product Name:	*Medicare Supplement Filing*		
Project Name/Number:	*AFLAC/61/61*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	08/21/2012
Comments:			
Attachment(s):			
AR RDB1.pdf AR RDB2.pdf AR RDB3.pdf AR RDB4.pdf AR RDB5.pdf AR RDB6.pdf AR COC.pdf AR COC2.pdf AR COC3.pdf AR COC4.pdf AR COC5.pdf AR COC6.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	08/21/2012
Comments:	The application to be used for these policies is attached to the Form Schedule.		

		Item Status:	**Status Date:**
Satisfied - Item:	Outline of Coverage	Approved-Closed	08/21/2012
Comments:	The Outline of Coverage has been attached to the Form Schedule.		

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: American Family Life Assurance Company of Columbus

This is to certify that the forms referenced below have achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
A19MSARAR	46.9
A19MS1R	*
ACOCRAR	*
AC-ATA	*
ACREST	*
A19MS15	*
A19MS4	*

*This achieves a score of at least 45+ when scored with the policy.

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: American Family Life Assurance Company of Columbus

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
A19MSCRAR	49.2

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: American Family Life Assurance Company of Columbus

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
A19MSDRAR	49.7

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: American Family Life Assurance Company of Columbus

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
A19MSFRAR	50.7

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: American Family Life Assurance Company of Columbus

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
A19MSGRAR	51.8

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: American Family Life Assurance Company of Columbus

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
A19MSNRAR	52.0

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: American Family Life Assurance Company of Columbus

Form Titles: Outline of Coverage, Application for Medicare Supplement Insurance, Amendment of Application, Application for Reinstatement, Notice to Applicant Regarding Replacement, Request for Change, Medicare Supplement Insurance Policy – Plan A

Form Number: ACOCRAR, A19MS1R, AC-ATA, ACREST, A19MS15, A19MS4, A19MSARAR

I hereby certify that to the best of my knowledge and belief, the above forms and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: American Family Life Assurance Company of Columbus

Form Title: Medicare Supplement Insurance Policy – Plan C

Form Number: A19MSCRAR

I hereby certify that to the best of my knowledge and belief, the above form and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: American Family Life Assurance Company of Columbus

Form Title: Medicare Supplement Insurance Policy – Plan D

Form Number: A19MSDRAR

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

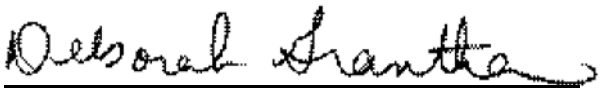
CERTIFICATION OF COMPLIANCE

Company Name: American Family Life Assurance Company of Columbus

Form Title: Medicare Supplement Insurance Policy – Plan F

Form Number: A19MSFRAR

I hereby certify that to the best of my knowledge and belief, the above form and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

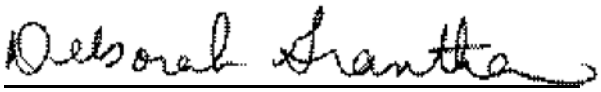
CERTIFICATION OF COMPLIANCE

Company Name: American Family Life Assurance Company of Columbus

Form Title: Medicare Supplement Insurance Policy – Plan G

Form Number: A19MSGRAR

I hereby certify that to the best of my knowledge and belief, the above form and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: American Family Life Assurance Company of Columbus

Form Title: Medicare Supplement Insurance Policy – Plan N

Form Number: A19MSNRAR

I hereby certify that to the best of my knowledge and belief, the above form and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Deborah Grantham
Second Vice President, Compliance

July 20, 2012
Date